

lignant. In most cases a round, flat, suppurating tumor constricted at the base develops in the midst of the lupus, and involves the deep seated parts very rapidly. There is rapid loss of strength, accompanied by fever, sleeplessness, rapid emaciation. The soil of lupus is favorable to such a malignancy (Kaposi, Lang). In ten operated cases, rapid return of the growth occurred in seven. In only one case is a cure recorded (Volkmann). Therefore early interference with the knife is indicated in these growth.—*Beitrage zur klin. Chir. von Paul Bruns, Tübingen, 1887.*

CHEST AND ABDOMEN.

I. "Perineal Hernia." By LUDWIG EBNER (Graz). This monograph has for its object the investigation of the anatomical characters of this variety of herniæ, their classification and their probable ætiology. The dissections conducted in the anatomical institute of Prof. Zuckerkandal extend over a material of sixty subjects. The peritoneum in the first place on the floor of the pelvis is quite distant from the levator ani and in normal conditions it is so remote in the region of Douglas' pouch and so markedly distant at the sides in the region of the bladder that hernia is impossible. In males the peritoneum reaches as far as the trigone, in females to the posterior wall of the bladder. In exceptional cases the peritoneum stretches to the prostate, in female to the space between the rectum and the vagina. In these cases the possibility exists of the small intestine sinking lower than usual. But in perineal herniæ the peritoneal diverticulum must reach still nearer the floor of the pelvis.

A preparation of the levator ani next undertaken for the explanation of the anatomical origin of the hernia showed that in 25 individual subjects 47 distinct separations of the muscular fibres at the floor of the pelvis could be demonstrated: they existed between the levator and ischio-coccygeus (Henle) and between the ischio-coccygeus (Henle) and coccygeus.

Spaces between the muscular fibres are abundant in the levator. The resistance of the tissues in the cavum ischio-rectale will determine as to whether the hernia can be felt externally or not.

A hernia of this kind has for its external exit the opening in the levator, and its coverings are the skin, foot of the ischio-rectal fossa, the fascia of the pelvis, the subserosa and peritoneum.

A strongly-filled rectum exerts quite a pressure over the levator, and, though it is not mentioned in the literature, the rectum might easily form part of the contents of the hernial sac. The author has illustrated this by investigations and dissections of the perineal hernia in dogs. Though the clefts in the muscular tissue of the levator are closely connected with the causation of perineal hernia, their presence does not fully explain the same. The congenital anatomy of the peritoneum in Douglas' pouch, by which the same comes deeper toward the floor of the pelvis, is an important agent in the origination of these herniæ. A trauma alone without the presence of the above congenital pocket of peritoneum cannot cause these herniæ. Abdominal pressure, as in umbilical herniæ, may drive the coils of intestine into this pouch of Douglas, or any bodily exertion may likewise cause it. A subserous lipoma can hardly cause a perineal hernia. An investigation of the peritoneum in Douglas' pouch has shown it to be so delicate in embryo that it tears on the least manipulation. It is not hard to imagine that the peritoneum once torn, coils of intestine may easily be driven to and gain the floor of the pelvis. The author gives the following classification of these herniæ:

1. Those occurring in males taking a course between the bladder and rectum, causing a prominence in the perineum near the anus or scrotum (per. H. ant. or post.). In women likewise the course would be between the uterus and rectum and near the anus, or giving the patient a prominent tumor in the labium majus (H. per. post et H. labii maj. post. In the male the intestines may reach the floor of the pelvis, but cause no tumor (H. per. imperfecta). If the hernial sac or contents break into the rectum or bladder, we have a hydrocele or hernia into the bladder. In females we may have a protrusion of the posterior vaginal wall instead of the above.

2. In the female a hernia may originate between the bladder and uterus appearing externally in the labium majus (H. labii post). Here we may also have an anterior vaginal hernia into the bladder (H. vagin. ant.)

3. Hernia of the bladder (without sac) and also of the rectum may appear in the perineum. Rectocele vaginalis belongs to this class.

4. Hernia labii maj. anterior belongs rather to the class of inguinal hernia.

Author concludes that perineal herniæ are congenital. They are not capable of originating from traumatism alone. The cavum between the bladder and rectum, and the rectum and uterus is deeper and more pronounced in the embryo than later in life. It varies in different embryos. The hernia at first descends in the median line, and when it reaches the deeper structures takes a course laterally to either side. It passes especially between the levator and ischio-coccygeus muscles or ischio-coccygens and coccygeus muscles (Henle). These spaces can be easily demonstrated in man. All herniæ appearing at the outlet of the pelvis are varieties of the same class. The classification with reference to the transversus muscle is not practicable. Perineal herniæ in men, as in dogs, may be caused by constipation. Then follows a careful compilation of the cases of perineal hernia in the literature.—*Deutsch. Zeitschr. f. Chir.*, Bd. 26, Hft. 1 and 2.

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